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CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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CHAPTER IV COVERED SERVICES AND LIMITATIONS

The Virginia Medicaid Program covers a variety of psychiatric services under the Addiction and Recovery Treatment Services (ARTS), Community Mental Health Rehabilitation Services (CMHRS) and Psychiatric Services benefits for eligible members.. This chapter describes the requirements for the provision of Inpatient and Outpatient Psychiatric Services, including Mental Health Clinic Services.

All providers of psychiatric services are responsible for adhering to this manual, available on the DMAS website portal, their provider contract with the Managed Care Organizations (MCOs) and the Behavioral Health Services Administrator (BHSA), all DMAS policies and state and federal regulations.

BEHAVIORAL HEALTH SERVICES ADMINISTRATOR (BHSA)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and administration of the Fee for Service (FFS) behavioral health benefit programs under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a provider network; render service authorizations; adjudicate and process claims; gather and maintain utilization data; reimburse providers; perform quality assessment and improvement activities; conduct member outreach and education; resolve member and provider issues; perform utilization management of services; and, provide care coordination for members receiving Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan. DMAS shall retain authority for and oversight of Magellan entity or entities.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at: www.magellanprovider.com.

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MEDICAID MANAGED CARE ORGANIZATIONS (MCOs)

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS)

CCC Plus is a managed long-term services and supports (MLTSS) program. This mandatory Medicaid MCO program serves individuals with disabilities and complex care needs.

Target Population:

1. Individuals who receive Medicare benefits and full Medicaid benefits (dual eligible).
2. Individuals who receive Medicaid services in a facility or through the CCC Plus Waiver. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence Waivers, known as the Developmental Disabilities (DD) Waiver, enroll for their non-waiver services only. At this time, DD Waiver services continue to be covered through Medicaid FFS.
3. Individuals who are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups.

Additional information about the CCC Plus Program can be found at: <http://www.dmas.virginia.gov/#/cccplus>.

MEDALLION 4.0

Medallion 4.0 is the Medicaid MCO program effective August 1, 2018. Individuals enrolled in Medallion 3.0 MCOs will transition by region into Medallion 4.0 MCOs. Several services, including Community Mental Health Rehabilitative Services (CMHRS) and Early Intervention, that were not included in the Medallion 3.0 contract will be included in the Medallion 4.0 contract. Additional information is available on the DMAS website at <http://www.dmas.virginia.gov/#/med4> and in Medicaid Memos to providers dated January 8, 2018 and June 11, 2018 available on the DMAS website at: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

For MCO members, most Medicaid services are provided through the member's MCO. Providers must participate with the member's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the member's MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO.

Certain services, however, are carved out of managed care and will continue to be obtained through FFS (such as Dental Services, School Based Health Services and Residential Treatment Services).

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A complete list of carved out services are located in the MCO contracts posted online under Managed Care Benefits at: <http://www.dmas.virginia.gov/#/index> .

TRANSPORTATION

Non-emergency transportation for the individual receiving services to medical appointments, including psychiatric appointments, must be authorized by and billed to the Medicaid transportation broker or the member's assigned MCO broker and is not included as part of the psychiatric service. Individual providers and agencies, with the exception of state psychiatric hospitals, may seek mileage reimbursement through the transportation broker for services under which transportation is not covered should they transport individuals to appointments. Reimbursement for transportation is for mileage only. In order to bill for other covered services please refer to the specific service requirements in this chapter.

The current FFS transportation broker is LogistiCare and can be contacted at <https://member.logisticare.com> or by calling the LogistiCare reservation line at 1-866-386-8331 in order to arrange transportation services and complete forms for gas reimbursement. For more information regarding time frames for making reservations please refer to the LogistiCare website (www.logisticare.com). Individuals enrolled in an MCO must contact the individual's MCO broker directly in order to arrange transportation. Additional transportation information for individuals enrolled in managed care can be found by clicking on the "Managed Care Benefits" link on the DMAS website, <http://www.dmas.virginia.gov/#/index>.

PSYCHIATRIC SERVICES MEDICAL RECORD REQUIREMENTS

For information on medical record requirements, please refer to Chapter VI of this manual.

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INPATIENT PSYCHIATRIC SERVICES (ACUTE CARE HOSPITAL & FREESTANDING PSYCHIATRIC HOSPITAL)

DEFINITIONS

- “Active Treatment” means implementation of a professionally developed and supervised individual Plan of Care.
- “Ambulatory Care” means services provided in the individual’s home community, which may include but is not limited to: outpatient therapy, crisis intervention, psychosocial rehabilitation, therapeutic day treatment, intensive in-home services, or case management.
- “Licensed Mental Health Professional” or “LMHP” is as defined in 12VAC35-105-20 in addition to a licensed psychiatric/mental health nurse practitioner.

PSYCHIATRIC CARE IN ACUTE CARE HOSPITALS

Inpatient Acute Psychiatric services are available to individuals of all ages in psychiatric units of general acute care hospitals. Inpatient care is a covered service under the Medicaid program if it is reasonable and medically necessary for the diagnosis or treatment of the patient’s condition and must be rendered in accordance with standards of good medical practice to be considered medically necessary. Refer to the Hospital Provider Manual, Chapter IV, for specific, additional requirements for acute care facilities.

All medical necessity decisions about proposed admission and/or treatment for members in the FFS benefit are made by the LMHP/Care Manager with Magellan of Virginia after receiving a sufficient description of the current clinical features of the individual’s condition that have been gathered from a face-to-face evaluation of the individual by a qualified LMHP. Medical necessity decisions about each individual case are based on the clinical features of the individual relative to the individual’s socio-cultural environment, the medical necessity criteria, and the validated service resources that are available to the individual. The Magellan of Virginia medical necessity criteria is posted online at: <https://www.magellanofvirginia.com/for-providers/provider-tools/magellan-medical-necessity-criteria/>. In instances when Magellan of Virginia recognizes that a full array of services is not available to the individual or when a medically necessary level of aftercare does not exist (e.g., rural locations), Magellan of Virginia will support the individual through extra-contractual benefits, or authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the individual’s essential needs for safe and effective treatment. See Appendix C for service authorization information. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia.

For members enrolled in a Medicaid MCO, providers must adhere to the MCO’s requirements for service authorization. As provided in 42 CFR § 438.210 (a)(5)(i), the MCO’s medical necessity criteria shall not be more restrictive than the Department’s criteria. Contact the member’s MCO

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for specific service authorization information.

SERVICE REQUIREMENTS

Intensity of Treatment Required

1. The active plan of care must relate to the admission diagnosis and reflect the need for:

a. At least one of the following:

1. Physical restraint/seclusion/isolation; or
2. Suicidal/homicidal precautions; or
3. Escape precautions; or
4. Drug therapy (any route) requiring specific close medical supervision; and

b. All of the following:

1. A LMHP provides individual/group or family therapy on at least five out of seven days, in addition to the therapy session, at least one appropriate treatment intervention occurs on the same five out of seven days. No more than one individual therapy session per day is billable, and there is a maximum of ten individuals per group therapy session. On days when there is no individual, group, or family therapy, there must be at least two appropriate treatment interventions. Treatment interventions may include, but are not limited to psychoeducational groups, socialization groups, behavioral interventions, play/art/music therapy, and occupational therapy. Therapeutic treatment interventions may be facilitated by nurses, social workers, psychologists, mental health workers, occupational therapists, and other appropriately prepared hospital staff; and
2. The family, caretaker, or case manager is involved on an ongoing basis with treatment planning and family members participates in family therapy at a minimum of once per week unless documentation demonstrates, based on the plan of care, why it is not feasible and addresses alternative involvement in therapy; and
3. Active treatment and discharge planning begin at admission.

2. Medical record documentation must include all of the following:

- a. Stabilization or improvement of presenting symptoms with progress notes reflecting positive or negative reactions to treatment on a daily basis; and
- b. Continued necessity for skilled observation, structured intervention, and support that can only be provided at the hospital level of care; and

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- c. Concurrent documentation of therapeutic interventions (billable psychotherapy and non-billable interventions that meet the weekly requirement) as provided, including individual treatment, according to the plan of care, specific to hours and number of days provided, topics covered, and response to the therapy; and
 - d. Dated signatures of qualified providers; and
 - e. All medical documentation must also include the time the notations are made; and
 - f. If the minimum treatment outlined above is not provided, document why the individual was unable to participate.
3. Therapeutic Passes:
- a. One therapeutic day pass is allowed if the goals of the day pass are documented prior to the day pass and if, on return, the effect of the day pass is documented. If the first day pass is determined not to have reached the goals and indications exist, a second day pass may be permitted. Day passes, which are not a part of the written plan of treatment or documented as to expected and experienced therapeutic effect, are not permitted.
 - b. Overnight passes are not permitted.
4. Expected Outcome/Discharge - Continued hospital level-of-care is not appropriate and will not be covered when a lower level of care is appropriate to meet the individual's treatment needs.

FREESTANDING PSYCHIATRIC HOSPITALS

AGES 21-64 LIMITATION (INSTITUTION FOR MENTAL DISEASES (IMD) EXCLUSION)

Services for individuals, ages 21 to 64, are not reimbursable by Medicaid FFS in an IMD. "Institution for Mental Diseases" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with intellectual disabilities is not an IMD.

This exclusion does not apply to individuals enrolled in Medicaid MCOs. Contact the individual's MCO for additional information.

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CERTIFICATION OF NEED FOR CARE IN FREESTANDING PSYCHIATRIC HOSPITALS

The criteria for Medicaid reimbursement for freestanding inpatient psychiatric services has been established based on the federal regulations in 42 CFR § 441, Subpart D, and §§ 16.1-335 et seq and §§ 37.2-809 of the Code of Virginia. Any Medicaid-eligible individual seeking admission to a freestanding psychiatric hospital must be certified as requiring inpatient services in order for the psychiatric facility to receive Medicaid reimbursement for the admission.

A physician must certify for each individual that inpatient services in a freestanding psychiatric hospital are needed. The certification must be made within four hours of admission . If an individual applies for Medicaid assistance while in a freestanding psychiatric hospital, and becomes eligible for Medicaid during the hospitalization, the physician must certify the need for inpatient services before Medicaid or its contractor authorizes payment. Federal regulations (42 CFR §441.152) require certification by an independent team that inpatient psychiatric services are needed for any individual applying for Medicaid-reimbursed admission to a freestanding inpatient psychiatric facility. The certification must be current, within 30 days prior to placement. The independent team (42 CFR §441.153): includes a physician; who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and; has knowledge of the individual's situation. The team must sign the Certificate of Need/DMAS 370 form (See the "Exhibits" section at the end of Chapter IV for a sample form). The justification for certification must be individual-specific. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs.

According to 42 CFR §441.152, a Medicaid-reimbursed admission to a freestanding psychiatric facility can only occur if the independent team can certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the individual;
2. Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

The certification of need for freestanding psychiatric hospital admission must be documented on the Virginia Preadmission Screening Report, or similar form, which must be signed and dated by the screener and the physician (<http://www.dbhds.virginia.gov/behavioral-health/mental-health-services/protocols-and-procedures>). It is not sufficient to merely check on the Virginia Preadmission Screening Report that each of the above Certification-of-Need criteria has been met. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs.

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Any available medical, social, and psychiatric evaluations must be submitted with the Certification of Need to the freestanding inpatient psychiatric hospital. The Certification of Need must be completed and dated prior to admission and the request for authorization.

For individuals younger than 21 years of age, the need for inpatient psychiatric services should be identified as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening. For emergency acute care admissions, federal regulation (42CFR §441.153) allows up to 14 days for the team responsible for the Plan of Care in the facility to certify the admission. The certification must meet the criteria listed above. The team must meet the criteria for the treatment team (42CFR §441.156) listed in this chapter under the Comprehensive Individual Plan of Care (CIPOC) section. An emergency acute care admission is defined as a psychiatric hospitalization that is required, because the individual is a danger to himself or others or when the individual is incapable of developmentally appropriate self-care due to a mental health problem. The admission follows a marked reduction in the individual's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

For individuals who apply and become eligible for Medicaid while inpatient in the facility or program, the certification shall be made by the team responsible for the CIPOC and certification of need, within 14 days from admission. The certification shall cover any period of time before the application for Medicaid eligibility for which claims are made for reimbursement by Medicaid. The facility will not receive DMAS reimbursement approval until the certification of need is received by DMAS or its contractor.

A physician, physician's assistant, or nurse practitioner, acting within the scope of practice and under the supervision of a physician, must recertify for each individual that inpatient psychiatric services are needed. This recertification must be made at least every 60 calendar days that an individual continues to require inpatient psychiatric services per 12VAC30-60-25. For members enrolled in managed care, the provider shall consult with the specific MCO for certification and recertification requirements.

MEDICAL, PSYCHIATRIC, SOCIAL EVALUATIONS, AND ADMISSION REVIEW - FREESTANDING PSYCHIATRIC HOSPITALS

Prior to admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each individual's need for care in the hospital. In addition, appropriate professional personnel must make a psychiatric and social evaluation. Each medical evaluation must include:

1. Diagnoses;
2. Summary of present medical findings;
3. Medical history;

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4. Mental and physical functional capacity;
5. Prognosis; and
6. A recommendation by a physician concerning admission to the freestanding psychiatric hospital or continued care in the hospital for individuals who apply for Medicaid while in the freestanding psychiatric hospital.

INITIAL PLAN OF CARE - FREESTANDING PSYCHIATRIC HOSPITALS

In accordance with federal requirements (42 CFR § 441.155), prior to admission to a freestanding psychiatric facility or before authorization for payment, the attending physician or staff physician must establish a written Plan of Care for each individual. The Plan of Care must include:

- The diagnosis, symptoms, and complaints indicating the need for admission;
- A description of the functional level of the individual;
- Individual-specific treatment objectives with short- and long-term goals;
- Orders for medications, treatments, therapies, etc.;
- Plans for continuing care, including review of the Plan of Care;
- Prognosis; and
- Discharge plans.

The attending or staff physician and other personnel involved in the individual's care must review each Plan of Care at least every 30 calendar days per 42 CFR § 441.156.

DEVELOPMENT OF THE COMPREHENSIVE INDIVIDUAL PLAN OF CARE (CIPOC)

The Comprehensive Individual Plan of Care (CIPOC) is an individualized written plan of active treatment, designed to achieve the individual's discharge from inpatient psychiatric services at the earliest possible time.. In accordance with 42 CFR §441.154, the CIPOC must be developed and implemented no later than 14 calendar days after admission to a freestanding psychiatric hospital and must include the dated signatures of the team members specified in the federal requirements (42 CFR §441.156). The CIPOC must be developed by a team of professionals in consultation with the individual and the individual's parents, legal guardians, or others in whose care the individual will be released after discharge. In accordance with federal requirements (42 CFR § 441.156), the team must include one of the following:

- A Board-eligible or Board-certified psychiatrist; or
- A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases; and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by

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the state psychological association.

The team must also include one of the following:

- A psychiatric social worker; or
- A registered nurse with specialized training, or one year's experience, in treating individuals with mental illness; or
- An occupational therapist who is licensed, if required by the state, and who has specialized training, or one year of experience, in treating individuals with mental illness; or
- A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

The CIPOC must be completed before requesting continued stay. The CIPOC must meet the following requirements as set forth in 42 CFR § 441.155:

- Be based on diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and reflects the need for inpatient psychiatric care;
- Be developed by a team of professionals in consultation with the individual, and the individual's parents, legal guardians, or others in whose care the individual will be released after discharge;
- State individual-specific psychiatric treatment objectives that must include measurable short- and long-term goals with target dates for achievement;
- Prescribe an integrated program of therapies, activities, and experiences designed to the meet the stated objectives; and
- Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to achieve the individuals' discharge from inpatient status at the earliest possible time and ensure continuity of care with the individual's family, school, and community upon discharge.

The CIPOC must include the dated signatures of the professionals designated in 42 CFR §441.156, including the physician, and will be effective at the time of the last dated signature.

In addition, each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of the service provided under arrangement, any service that the individual needs while residing in a psychiatric facility, and that is furnished to the member by a provider of services under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Services provided under arrangement must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record

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will not meet this requirement. Each initial and comprehensive plan of care must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought.

See the “Exhibits” section at the end of Chapter IV for a sample form. The sample form is not required to be used as shown, but the CIPOC must, at a minimum, include all elements of the sample.

The diagnostic evaluation upon which the CIPOC is developed may include medical, social, and psychological evaluations that were completed prior to the individual’s admission to the freestanding psychiatric hospital and submitted with the Certification of Need as well as current medical and psychological evaluations. The social evaluation must include the psychosocial assessment and an evaluation of home plans and available community resources.

The CIPOC must be reviewed every 30 calendar days by the team specified in 42 CFR §441.156 listed above. The purpose of the review is to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the individual’s overall adjustment as an inpatient.

INDEPENDENT ASSESSMENT, CERTIFICATION AND COORDINATION TEAMS (IACCT) REFERRAL PROCESS: TRANSFER FROM INPATIENT PSYCHIATRIC SERVICES TO RESIDENTIAL TREATMENT SERVICES

For information about the IACCT process for individuals transferring from inpatient psychiatric services to residential treatment services, please refer to the Magellan of Virginia website at: <https://www.magellanofvirginia.com/for-providers/residential-program-process/>. Additional information about the IACCT process is also available in the DMAS Residential Treatment Services Manual.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES

As of June 30, 2017, Psychiatric Residential Treatment Facility services are defined in the Residential Treatment Services Manual.

TREATMENT FOSTER CARE - CASE MANAGEMENT (TFC-CM)

As of August 1, 2018, Treatment Foster Care - Case Management (TFC-CM) services are defined in the Community Mental Health Rehabilitative Services Manual.

OUTPATIENT PSYCHIATRIC SERVICES

Outpatient psychiatric services are provided in a practitioner’s office, mental health clinic,

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individual's home, or nursing facility. If services are provided in a setting other than the office or a clinic, this must be documented. All psychiatric services, including medication management shall be medically prescribed treatment, documented in an active written plan of care designed, signed, and dated by a LMHP.

Definitions:

- "Licensed mental health professional" or "LMHP" is as defined in 12VAC35-105-20 in addition to a licensed psychiatric/mental health nurse practitioner.
- "LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling.
- "LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology.
- "LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

Physician Direction of Mental Health Clinics

This section only applies to providers enrolled with Medicaid as Mental Health Clinic provider types.

Federal law requires that each mental health clinic be physician-directed. The physician does not have to be a psychiatrist. Under this policy, LMHPs, LMHP-Rs, LMHP-RPs, and LMHP-Ss may render reimbursable services without the direct personal supervision of a physician present.

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However, each mental health clinic must ensure that the federal requirement for the physician direction of the clinic is fully met. LMHP-Rs, LMHP-RPs and LMHP-Ss must also receive supervision as required by the appropriate licensing board. The clinic is required to maintain personnel files that include a copy of credentials for all staff that provide Medicaid-reimbursed services.

The State Medicaid Manual § 4320B, published by the Centers for Medicare and Medicaid Services (CMS), summarizes the federal requirements for physician direction.

“The requirement for physician supervision of all patient care in the mental health clinic is a condition of Medicaid reimbursement for mental health clinic services. The physician must have a face-to-face visit with the individual, prescribe the type of care provided, and if services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when individuals are receiving covered services, the physician must assume professional responsibility for the services provided and ensure that the services are medically appropriate. Thus, physicians who are affiliated with the clinic must spend as much time in the facility as is necessary to ensure that individuals are getting services in a safe and efficient manner in accordance with accepted standards of medical practice. For a physician to be affiliated with a clinic there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement.

The patient care protocols for treatment of Medicaid members must reflect the role of the physician. The individual’s medical records must document that the physician personally reviewed the individual’s medical history, conducted a thorough assessment, confirmed or revised the diagnosis, saw the individual face-to-face, reviewed and signed the plan of care, and is periodically reviewing the need for continued care. The LMHP, LMHP-R, LMHP-RP, or LMHP-S must conduct an intake interview with the individual, record the medical history, conduct the intake assessment, record a diagnosis, and develop the plan of care. If the plan of care is implemented, there must be no more than three sessions or no more than thirty days, whichever is least, before the face-to-face interview with the physician. If the individual is an existing patient of the physician and the physician has had a face-to-face interview within the past 30 days, the face-to-face meeting may be waived. However, the physician must still review the medical history and intake assessment, confirm the diagnosis, and review and sign the plan of care. The physician must document a review of progress and need for continued care every six months. This requirement must be met for all mental health clinic services billed to Medicaid.”

Medical Necessity Criteria

Outpatient psychiatric services shall be considered appropriate when an individual meets all of the following criteria:

- a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive

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functional levels that have been impaired; and

b. Exhibits deficits in peer relations, dealing with authority; is hyperactive; has poor impulse control; is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, ability to learn, or ability to participate in employment, educational, or social activities; and

c. Is at risk for developing or requires treatment for maladaptive coping strategies; and

d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

A psychiatric diagnostic interview examination may occur prior to the start of services. The psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory, or other medical diagnostic studies. Review of records or reports are included in the interview examination.

A co-occurring disorder is the presence of substance use and mental health disorders occurring simultaneously without implication as to the causal effect of one over the other, nor which disorder is primary versus secondary. Individuals who are experiencing a co-occurring substance use and mental health disorder may experience greater impairments in functioning. Thus providers who are trained and practicing within the scope of their practice, in working with individuals with both substance use and mental health disorders should ensure both conditions are addressed in treatment. If a provider is not trained in treatment of both substance use and mental health disorders, they should refer the member to an appropriate service provider. Both providers should obtain a release of information from the member so they can collaborate to coordinate effective treatment.

For persons with co-occurring psychiatric and substance use disorders, providers are expected to integrate the treatment needs. There may be concurrent authorizations for psychiatric services and substance use disorder services if medical necessity criteria are met for the requested service. Collaboration and coordination of care among all treating practitioners shall be documented.

Effective April 1, 2017, DMAS will implement Addiction and Recovery Treatment Services (ARTS) program for all members. For more information on the services, criteria, and staffing requirements, refer to the ARTS Provider Manual.

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PLAN OF CARE (ELEMENTS OF THE INITIAL AND ONGOING PLAN OF CARE)

A Plan of Care (POC) is required for all psychiatric services, including medication management. Requirements for the POC include:

- The initial Plan of Care (POC) shall be developed at the first appointment to address the immediate service, health, and safety needs for the member in outpatient psychiatric settings based on the licensed practitioner assessment in collaboration with the member..
- The focus of the POC must be related to the diagnosis. The individual must have a current documented DSM-psychiatric diagnosis which is documented along with the individual's current mental status in the medical progress notes.
- The POC must indicate:
 - individual-specific goals related to symptoms and behaviors;
 - treatment modalities used and documentation specific to the appropriateness of the modalities (why the modality was chosen for this individual; all modalities will be considered with appropriate documentation);
 - estimated length that treatment will be needed;
 - frequency of the treatments/duration of the treatment; and,
 - documentation of the family/caregiver participation.
- A LMHP must sign and date the plan of care. If the plan of care was developed by an LMHP-R, LMHP-RP or LMHP-S, the plan of care must contain the dated co-signature of the supervising provider within one business day from the date the service was rendered indicating that he or she has reviewed the plan. The direct supervisor can be the licensed program supervisor/manager for the agency
- The POC must be reviewed by the qualified provider every 90 calendar days or every sixth session, whichever time frame is shorter, from the date of the provider's signature. The review may be incorporated into the progress notes, but must be identifiable as a review of the POC. The review includes the following:
 - Has there been a relapse?

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- Has there been a significant change in the environment?
- Is the individual at risk for moving to a higher level of care?
- Positive/negative changes relative to the symptoms.
- Documented review of the plan of care by the qualified provider.
- The POC must be amended as needed throughout the time of treatment.

SPECIFIC SERVICE LIMITS

Beginning on July 26, 2017 outpatient psychiatric services do not require service authorization. Service limits are based on medical necessity.

The individual must participate and benefit from treatment in accordance to the plan of care.

There is a maximum of ten individuals per group session. Groups are expected to be held for a minimum of 30 minutes.

Family therapy is expected to be held for a minimum of 30 minutes.

Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with an intellectual disability prior to admission to a nursing facility, or any placement issue. Medical records must document the medical necessity for these tests.. The provider must support the units billed with documentation as to the medical necessity for the testing and a list of the specific tests conducted..

Separate payment is allowed for the attending physician and the anesthesiologist involved in electroconvulsive therapy.

NON-COVERED SERVICES

The following are non-covered services:

- Multiple-family group therapy.
- Services for sensory stimulation, recreational activities, art classes, excursions, or eating together are not included as group therapy.
- Broken appointments;

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- Remedial education (tutoring, mentoring);
- Day care;
- Psychological testing done for purposes of educational diagnosis or school admission or placement;
- Occupational therapy;
- Teaching “grooming” skills, monitoring activities of daily living, bibliotherapy, reminiscence therapy, or social interaction are not considered psychotherapy and remain non-covered;
- Telephone consultations;
- Mail order prescriptions;
- Case management as part of outpatient therapy services;
- Treatment team meetings;
- Interpretation of examinations, procedures and data, and the preparation of reports are non-covered services. This includes CPT code 90885 (psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes).
- Medical hypnotherapy and environmental intervention.

TELEHEALTH SERVICES

Coverage of services delivered by telehealth are described in the “Telehealth Services Supplement”.

MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

CARE COORDINATION

Care coordination is essential in the process of assisting a person experiencing a mental illness to access a range of different services in a way that helps them get better, improves access to care and works towards their recovery. It involves interactions between different clinicians and health care providers, the individual, their caregivers, family members and other significant persons.

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The goal of care coordination is to improve the health and functioning of people with mental health issues. Care coordination may include working with multidisciplinary teams, psychosocial support providers and self-management, in addition to clinical treatment. DMAS encourages providers to coordinate care with other behavioral health providers for the benefit of the member and as appropriate. Care coordination has two (2) main goals: 1) to improve the health and wellness of individuals with complex and special needs; and 2) to integrate services around the needs of the individual at the local level by working collaboratively with all partners, including the individual, family and providers. Please contact Magellan of Virginia or the member's MCO for additional resources to assist with care coordination.